# SUPERVISOR'S REPORT OF MOTOR VEHICLE ACCIDENT

**This form does not replace regular accident reports that may be required by the insurance carrier, or by any governmental agencies. Its purpose is to establish specific causes of the accident leading to suitable corrective action. Please submit completed copies to Finance and HR.**

1. **Driver**:_____ **Department:**_____
2. **Type of Accident**. (Head-on, Sideswipe, Rear End, Backing, Etc.)_____
   _____
3. **Type of Vehicle, Identifying Vehicle Number #, Make, Model**:_____
   _____
4. **Location of Accident**:_____
   _____
5. **Date and Time of Accident**:_____
6. **Persons Injured** and extent of **Property Damage**:_____
   _____
   _____
7. **Description of Accident**: What Happened?_____
   _____
   _____
   _____
   _____
   _____
8. **Unsafe Conditions**: (Weather, Equipment, Lights, Working Conditions, Etc.)___
   _____
   _____
   _____
   _____
   _____
9. **Unsafe Act**: (Describe the unsafe act of the driver, improper turn, no signal, failure to yield, Etc.)_____
   _____
   _____
10. **Corrective Action**: (Necessary to prevent reoccurrence.)_____
    _____
    _____
    _____

**Supervisor:** _____
**Reviewed By**: _____
**Date Prepared**: _____

**Employee sent for post accident drug screen**: Yes No